AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155711	A. BUII	LDING	00	1	
		155711	B. WIN			04/21/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
НІСНІ ЛІ	HIGHLAND MANOR HEALTHCARE				ORTH CAPITOL AVENUE IAPOLIS, IN46208		
					HAPOLIS, IN40200		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
F0000	negoe.nom on		1				Bille
10000	l a						
		the Investigation of	F0	000			
	•	988734. This visit					
	resulted in a Parti						
	Survey-Immediat	te Jeopardy.					
	Commission DIOOC	000724 Cubatantintal					
	_	988734 - Substantiated.					
		elated to the allegations					
	are cited.						
	Unrelated deficie	maing and aited					
	Omerated deficie	nicles are ched.					
	Survey dates: Ar	oril 18 and 19, 2011					
		dates: April 20 and 21,					
	2011	dates. April 20 and 21,					
	2011						
	Facility number:	000567					
	Provider number:						
	AIM number:	100289560					
	7 HIVI Hamoor.	10020)300					
	Survey team:						
	Connie Landman	RN TC					
	Diana Zgonc RN						
	C						
	Census bed type:						
		29					
	SNF:	3					
	NF:	16					
	Total:	48					
	Census Payor Ty	pe:					
	Medicare:	4					
	Medicaid:	44					
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6MTI11

Facility ID:

000567

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2926 NORTH CAPITOL AVENUE						
HIGHLAI	ND MANOR HEALT	HCARE		INDIAN	APOLIS, IN46208				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	Total:	48							
	Sample Supplemental san	3 mple 8							
		es also reflect state dance with 410 IAC 16.2.							
Quality review completed 4/25/11 by Jennie Bartelt, RN.									
F0225	have been found of or mistreating resistance had a finding nurse aide registry neglect, mistreatm misappropriation of any knowledge it have against an emindicate unfitness or other facility staregistry or licensing. The facility must eviolations involving abuse, including in and misappropriating reported immediate.	ensure that all alleged g mistreatment, neglect, or njuries of unknown source tion of resident property are tely to the administrator of other officials in accordance							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155711 04/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2926 NORTH CAPITOL AVENUE HIGHLAND MANOR HEALTHCARE INDIANAPOLIS, IN46208 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated. and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident. and if the alleged violation is verified appropriate corrective action must be taken. SS=K All residents have the potential to 04/21/2011 Based on record review and interview, the F0225 be affected. Posting of facility failed to ensure allegations of staff procedure for Abuse known and to resident and resident to resident abuse or alleged policy with action steps and staff neglect of residents were at central time clock for every employee to see every in/out reported immediately to the administrator scheduled. Resident Council for investigation and protection of given policy and procedure on residents. The facility also failed to report Abuse Protection and allegations of abuse and neglect to the Investigation. All Families and guardians mailed policy and Indiana State Department of Health. The procedure on Abuse Protection facility also failed to thoroughly and Investigation. All staff investigate the allegations and protect in-serviced on 4-21-2011 and residents during investigation. The repeated on 5-5-2011 on facility also failed to identify 5 of 9 expanded grievance form which now includes signature lines for grievance/concerns filed as allegations of Administrator, Executive Director, abuse. The deficient practice affected 7 of Director of Nursing and Social 8 residents from a sample of 3 and a Services Director. Form includes supplemental sample of 8 identified in 5 policy and step- by-step instructions on investigation of 9 grievance/concern documents procedures and reporting reviewed related to allegations of abuse. procedures including notification (Residents E, F, G, K, L,M, and N). of Administrator, Director of Nursing, Social Services Director

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MULTI A. BUILDIN B. WING		NSTRUCTION 00	(X3) DATE S COMPLI 04/21/2 (ETED	
	PROVIDER OR SUPPLIER		S ^r 2	926 NC	DDRESS, CITY, STATE, ZIP CODE DRTH CAPITOL AVENUE APOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	·E	(X5) COMPLETION DATE
	jeopardy was ide began on 3/8/11. was notified of the on 4/19/11 at 11: developed a plant Immediate Jeopa interview and review and replaced in the Executive Di P.M., titled "Abu" "Policy It is the policy of residents from all comply with stat regulations for reactual acts. Procedure: 15. The Admishall immediately all incidents. All completed within days" The guidelines for the policy of t	rdy. The immediate entified on 4/19/11 and The Executive Director the Immediate Jeopardy 10 A.M. The facility for removal of the ardy, but based on view of administrative was not effective to ediate Jeopardy prior to the survey.			and Executive director. All statin-serviced with pre/post testin by Director of Nursing on Abus Grievances, Reportable, and Abuse Protection and Investigation policies and procedures on 4-21-2011 and repeated on 5-5-2011. Medica Director in-serviced Executive Director and Director of Nursin on 4-21-2011. Executive Directin-serviced Administrator on 4-21-2011. Executive Directo and Administrator are respons for auditing done in daily meet with all Department Heads, weekly with Chief Operating Officer and QA Monthly for thremonths and quarterly thereafte Effective 4-21-2011 and on-go	ng se, al g ctor r ible ing	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/10/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2926 NORTH CAPITOL AVENUE INDIANAPOLIS, IN46208					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	to the Indiana St will be recorded to insure residen appropriate care Procedure: Faci to report unusual hours of occurre Care Division that all alleged v mistreatment, ne injuries of unknown misappropriation reported immedi of the facility an accordance with established procestate Survey and The following ar occurrences that Division consides State Rule and Foccurrences will and will be track (1) Abuse Abuse is willful unreasonable corpunishment with or pain, anguish, individual of goon necessary to attamental, or psych (A) Physical abuse is willful abuse and the processory to attamental, or psych (A) Physical abuse is will abuse and the processory to attamental, or psych (A) Physical abuse is willful abuse and the processory to attamental, or psych (A) Physical abuse is willful abuse and the processory to attamental, or psych (A) Physical abuse is will abuse and the processory to attamental, or psych (A) Physical abuse is will abuse and the processory to attamental, or psych (A) Physical abuse is will abuse and the processory to attamental, or psych (A) Physical abuse is will abuse and the processory to attamental, or psych (A) Physical abuse is will abuse and the processory to attamental abuse and the processor to a proce	and services. lities are required by law loccurrences within 24 mee to the Long Term the facility must ensure iolations involving glect, or abuse, including own source and n of resident property are ately to the administrator d to other officials in State law through edures (including to the l Certification Agency). The examples of the Long Term Care are reportable under both ederal Regulation. These be recorded by facility ed and monitored. Infliction of injury, Infinement, intimidation or resulting physical harm or deprivation by an ods or services that are in or maintain physical, osocial well being.						

000567

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED	
NAME OF 1	PROVIDER OR SUPPLIEF	"			ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAI	ND MANOR HEALT	HCARE		1	ORTH CAPITOL AVENUE APOLIS, IN46208		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	without injury	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	1	se - is defined as the use					
	` ′	and/or gestured language					
		ludes disparaging and					
	derogatory terms						
	1) Staff to reside	ent - any episode,					
	2) Resident to re	sident verbal threats of					
	harm"						
	An undated police	cy, provided by the DON					
	_	sing) on 4/20/11 at 11:40					
	· ·	use Investigation"					
	indicated:	C					
	Policy:						
	Nursing Homes	must ensure that all					
	alleged violation	s involving mistreatment,					
	"	e, including injuries of					
	1	, and misappropriation of					
	resident property	-					
	1	he Administrator					
	`	etor) of the facility and the					
		partment of Health.					
		mediately means as soon not to exceed 12 hours					
	after discovery						
	1	f this facility that all					
	1 .	nt abuse, neglect and					
	_	known source shall be					
	1 *	ed and thoroughly					
	investigated by f	acility management as					
	required by the f	ederal regulations.					
	Procedure:						
		eident or suspected					
	incident of resid	ent abuse, neglect, or					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155711	A. BUII		00	04/21/2	
		1557 11	B. WIN		ADDRESS STEEL STATE STATES	04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE		
HIGHLAN	ND MANOR HEALTI	HCARE		1	APOLIS, IN46208		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 " "	nown source be reported					
		rector, or his designee					
	I -	investigate the alleged					
	incident						
		investigation will be					
	1	the following as part of					
	the investigation:						
	a. Review the co	*					
		laint Investigative Report					
		sident's medical record to					
		leading up to the					
	incident						
	l '	person(s) reporting the					
	incident						
	I	witnesses to the incident					
		resident (as medically					
	appropriate)						
		resident's attending					
	l ^	rmine the resident's					
	current mental st						
	-	f members (on all shifts)					
		ntact with the resident					
	1	l of the alleged incident					
		resident's roommate,					
	family members,						
		of this facility who have					
		resident abuse may be					
	_	duty until the Executive					
		ewed the results of the					
	investigation						
		e investigation reveal that					
	a false report was						
	· ·	l cease. Residents,					
	family members,	Ombudsmen, state					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE : COMPL		
		155711	A. BUI B. WIN	LDING		04/21/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIER			2926 N	ORTH CAPITOL AVENUE		
	ND MANOR HEALTI			INDIAN	APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·		IAG			DATE
	agencies, etc., will be notified of the findings"						
	imamgs						
	During the entrar	nce conference with the					
	Executive Direct	or on 4/18/11 at 9:15					
	A.M., he indicate	ed the Administrator was					
	at the facility's co	orporate office.					
		conference with the					
		or on 4/18/11 at 4:30					
	P.M., a request w						
	1	nine grievances/concerns					
	filed in the last 3	months.					
	On 4/19/11 at 8:1	10 A.M., these					
		ere provided by the					
	Executive Direct						
	1. A Grievance/0	Concern, filed by					
		M on 3/8/11, indicated					
		and abrupt when					
		ll light - slow to respond.					
		(symbol for with)					
	`	sidents). Turns not being					
		doesn't come into room					
		entire noc (night) (symbol					
	for without) bein						
	_	ne by the DON (Director cated she spoke with the					
		ed) regarding staff					
	,	resident complaints.					
	1 ^	ted "per nurse she has					
		attitude (symbol for and)					
	1	l for with) all CNAs and					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPL	ETED
		155711	B. WIN			04/21/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	· ·		2926 N	ORTH CAPITOL AVENUE		
	ND MANOR HEALT	HCARE			APOLIS, IN46208		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION) states when she hears the referenced		-	TAG	DEFICIENCY)		DATE
	1	ng verbal she goes to area					
	1	ig is wrong or behavior					
		riate). States she had					
		(turn and position)					
	(symbol for with	n) another CNA."					
	The DON also in	ndicated in the					
	investigation she	e had spoken to CNA #2					
	regarding how h	-					
	1 ~ ~	sive and to be aware of					
		ne is saying may sound to					
	1	N indicated she reviewed					
		'NA to "clarify that tone					
	alone may be rea						
	alone may be rea	id as abuse.					
	The DON also s	poke to the two residents					
	during the invest	tigation who indicated the					
	CNA sounded di	isrespectful.					
	The DON was n	ot available to be					
		1 4/20/11 at 9:30 A.M.					
		view, the DON indicated					
	1	from her investigation,					
	1	M were abused or felt					
		unaware the allegation					
	1	n reported to the State					
		•					
	Agency. Also during that interview, the						
	DON indicated she thought the Executive						
	1	Administrator, and she					
	nad reported to t	he Executive Director.					
		1 1 11 2 2					
	1	n lacked documentation					
	from staff involv	ved. The incident was not					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	COMPI		
AND TEAN	or conduction	155711	- 1	LDING		04/21/2	
		100711	B. WIN		DDRESS, CITY, STATE, ZIP CODE	0 1/2 1/2	
NAME OF I	PROVIDER OR SUPPLIER				ORTH CAPITOL AVENUE		
HIGHLA	ND MANOR HEALT	HCARE		1	APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	BEIGERGI		DATE
	1 ^	tate Agency. The ern form lacked the					
		Administrator, which the					
	form indicated w						
	lorin maleated w	as necucu.					
	 During interview	with the Executive					
	_	/11 at 11:10 A.M., he					
		Grievance/Concerns are					
		etings, along with					
		ner it was felt to be abuse					
	or not. When qu	eried as to whether the					
	_	d been informed of these					
	incidents or was	a part of the meetings,					
	the Executive Di	rector indicated he					
	(Executive Direc	etor) knew about them,					
	but was unable to	o provide information as					
	to whether the A	dministrator was aware					
	of the incidents.						
	2. On 3/16/11, a	Grievance/Concern was					
	1 *	t K. The form indicated					
		crying and she indicated					
	_	her on the jaw and CNA					
	#6 had done that	•					
		ated she did not want					
		g her. Family member					
	present.						
	The DON's inves	stigation indicated CNA					
	#6 was sent hom	e that day and was to					
	meet with the Do	ON on 3/21/11 to review					
	counseling and r	equired performance.					
	"Per interview (s	ymbol for with) staff - no					
	one saw this occ	ur." CNA #6's					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155711	B. WIN	G		04/21/20	011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	NO VIDER OR SETTEIER			1	ORTH CAPITOL AVENUE		
HIGHLAN	ND MANOR HEALT	HCARE		INDIAN	APOLIS, IN46208		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	-	adjusted so CNA #6					
	would not care for	or Resident K again.					
	D . COMA	// L 1 1					
		#6's employee record on					
		A.M. indicated CNA #6					
	1	6/11, 3/17/11, and					
	·	interview with the DON					
		0 A.M., she indicated					
	1	ot off duty until she was					
	1 ^	her investigation and					
	counsel the empl	loyee.					
	The increase and in	. did					
	The investigation						
		r interviews with					
		e family member, or a					
	statement by CN	A #6.					
	During interview	on 4/20/11 at 9:30 A.M.,					
	~	ed she did not feel the					
		se, because Resident K					
	l -	sations in the past, and					
		t the allegation to the					
	_	he indicated she informed					
		rector, but had not					
	informed the Adı						
	informed the Adi	mmstrator.					
	 During interview	with the Executive					
	_	/11 at 11:10 A.M., he					
		Grievance/Concerns are					
		etings, along with					
		ner it was felt to be abuse					
		eried as to whether the					
	_	id been informed of these					
		a part of the meetings,					
	meracinis or was	a part of the meetings,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MUL' A. BUILD! B. WING		NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED	
	PROVIDER OR SUPPLIEF		:	2926 NC	DDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE APOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFEERINGED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	the Executive Direct Executive Direct but was unable to to whether the A of the incidents. 3. A grievance/of E, on 3/30/11, in	rector indicated he etor) knew about them, to provide information as dministrator was aware etoncern filed by Resident dicated CNA #3 called M F, I'll kill you					
	and pushed him into his wheelchair Also, CNA #3 threw his "reacher" onto the floor.						
	indicated (an unithe Nurses' Station resident (E) was directed at her was provide care for (unidentified) at room to provide	dentified) CNA came to on and reported the using abusive language hen she had gone in to another resident. CNA and CNA #3 went into the care. Both CNAs nt E was sitting with his					
	from the CNAs i	n lacked documentation nvolved, interview with s visitor or a resolution to					
	the DON indicat incident was abu physical contact	on 4/20/11 at 9:30 A.M., ed she did not feel the se, because there was no and no injury, and she e allegation to the State					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE :		
AND PLAN	OF CORRECTION	155711	A. BUI	LDING	00	04/21/2	
		1557 11	B. WIN			04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
HIGHI AN	ND MANOR HEALTI	HCARE		1	ORTH CAPITOL AVENUE APOLIS, IN46208		
					711 0210, 11110200		(2/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	, i	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Agency She ind	licated she informed the					
	" '	or, but had not informed					
	the Administrator						
		-					
	During interview	with the Executive					
	~	/11 at 11:10 A.M., he					
		Grievance/Concerns are					
	discussed in mee						
		er it was felt to be abuse					
	or not. When qu	eried as to whether the					
	Administrator ha	d been informed of these					
	incidents or was	a part of the meetings,					
		rector indicated he					
	(Executive Direc	tor) knew about them,					
	1 '	provide information as					
		dministrator was aware					
	of the incidents.						
	4. On 4/1/11, a (Grievance/Concern was					
	filed by CNA #5	for Resident G. The					
	concern indicated	d Resident N was					
	standing over Re	sident G (who was in					
	bed) with his fist	balled making					
	threatening (unal	ole to read) toward					
	Resident G.						
	The DON's inves	stigation indicated she					
	spoke to Residen	t N who indicated there					
	wasn't anything v	wrong with his doing that					
	to Resident G and	d demonstrated what he					
	did, which was w	what was stated in the					
	complaint. The r	resolution was to change					
	Resident N's room	m after discussion with					
	the Social Servic	es Director and					

AND PLAN OF CORRECTION IDENTIFY		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED
NAME OF I	PROVIDER OR SUPPLIE	 	P. (12)	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u>!</u>	
	ND MANOR HEALT				ORTH CAPITOL AVENUE APOLIS, IN46208		
		STATEMENT OF DEFICIENCIES		ID	AI OLIS, IN40200		(V5)
(X4) ID PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE	
	communication with the guardian of Resident N.						
	During an interv	iew with the DON on					
	_	A.M., she indicated she					
	was unaware a r	esident making a threat to					
	another resident	was abuse, she thought it					
		al contact. She indicated					
		rt the allegation to the					
	Administrator or	to the State Agency.					
	During interviev	w with the Executive					
		/11 at 11:10 A.M., he					
	indicated these (Grievance/Concerns were					
	discussed in med	etings, along with					
	discussion whetl	ner it was felt to be abuse					
	or not. When qu	ieried as to whether the					
		ad been informed of these					
		a part of the meetings,					
		irector indicated he					
	\	etor) knew about them,					
		o provide information as dministrator was aware					
	of the incidents.	diffinistrator was aware					
	of the incidents.						
	5. On 4/1/11, a	Grievance/Concern form					
	was filed by Res						
	,	g spoken to "abruptly by					
		And inconsistent turning					
	and positioning	by CNA on 11 - 7.					
	The DON's inve	stigation indicated she					
		se and CNA (unidentified					
		e/Concern form and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155711		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 04/21/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEI	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
				I	ORTH CAPITOL AVENUE		
HIGHLA	ND MANOR HEALT	HCARE		INDIAN	APOLIS, IN46208		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPLICATION SHOULD DEFICIENCY)			
IAG	†	n 4/4/11 and discussed	-	IAG	DEI TOLERO I I		DATE
	1	roach and response to					
	1	ON indicated she					
		erformance expectations					
	_	clarify baseline of					
	acceptable perfo	rmance. Counseling will					
	follow for repear	t.					
	-	n lacked documentation					
		h Residents L and M. The					
	1	I not identify the nurse or					
	CNA.						
	During an interv	riew with the DON on					
	"	A.M., she indicated she					
		esident making an					
		receiving needed care					
	during the night	would fall under an abuse					
	category. She in	ndicated she did not report					
	this incident to t	he Administrator or the					
	State Agency.						
	D	id d. E. di					
	1	with the Executive					
		/11 at 11:10 A.M., he Grievance/Concerns are					
		etings, along with					
		her it was felt to be abuse					
		neried as to whether the					
	_	ad been informed of these					
		a part of the meetings,					
		irector indicated he					
	(Executive Director) knew about them, but was unable to provide information as						
	to whether the A	dministrator was aware					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION		(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		COMPL	
		155711	B. WIN	IG			04/21/2	U11
NAME OF F	ROVIDER OR SUPPLIER			1	DDRESS, CITY, STAT			
				1	ORTH CAPITOL			
HIGHLAN	ND MANOR HEALTI	HCARE		INDIAN	APOLIS, IN46208	3		
(X4) ID		TATEMENT OF DEFICIENCIES		ID		AN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		TO THE APPROPRIAT	PPROPRIATE CONTINUE TO	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFIC	JENCY)		DATE
	of the incidents.							
	eest							
		or was unavailable for						
	interview during	the survey dates.						
		copardy was identified on						
	4/19/11 at 11:00 A.M. The Immediate							
		on 3/8/11 when two						
	•	ined a CNA was short						
	•	responding to their call						
	-	adn't been turned all						
	night shift. The Executive Director was							
		nmediate Jeopardy on						
		A.M. related to the lack						
		use and/or neglect,						
	•	tigation of complaints,						
	and failure to rep	ort alleged abuse to the						
	Indiana State Dep	partment of Health for 5						
	of 9 concerns/cor	mplaints reviewed for the						
	last 3 months. Th	ne facility staff submitted						
	a plan of action to	o remove the Immediate						
	Jeopardy on 4/20	0/11 at 8:30 A.M. Based						
	on interview and	review of administrative						
	records on 4/20/1	11, it was determined the						
	plan of action had	d not removed the						
	Immediate Jeopa	rdy and the Immediate						
	Jeopardy continu	ed because of concerns						
	with understanding	ng abuse and abuse						
	investigations and	d protocols. This failure						
	_	mediate Jeopardy						
		applemental and 3						
		s (Residents E, F, G, K,						
	L, M, N).	, , , , ,						
	, , - · /·							
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID:	I 6MTI11	Facility I	D: 000567	If continuation sh	eet Pa	ge 16 of 58

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/21/2011
	PROVIDER OR SUPPLIER		2926 N	ADDRESS, CITY, STATE, ZIP CODE IORTH CAPITOL AVENUE NAPOLIS, IN46208	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=K	written policies and mistreatment, negrand misappropriated Based on record the facility failed policy and proces identifying, investigating allegating for 7 of 8 resider sample of 8 identifying of a began on 3/8/11. was notified of the sample of 3.	stigating, protecting, and ions of abuse and neglect ats from a supplemental tified in 5 of 9 ern forms reviewed for use and neglect and a sidents E, F, G. K, L, M,	F0226	All residents have the potentibe affected. Posting of procedure for Abuse known a or alleged policy with action sat central time clock for every employee to see every in/out scheduled. Resident Council given policy and procedure of Abuse Protection and Investigation. All Families an guardians mailed policy and procedure on Abuse Protectic and Investigation. All staff in-serviced on 4-21-2011 and repeated on 5-5-2011 on expanded grievance form whow includes signature lines and Administrator, Executive Dire Director of Nursing and Social Services Director. Form inclupolicy and step- by-step instructions on investigation procedures and reporting	ich for ctor,

000567

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2)	MULTIPLE CO	NSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00		COMPLETED	
		155711	B. W	ING			04/21/2011	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODI	•		
				1	ORTH CAPITOL AVENUE			
HIGHLAN	ND MANOR HEALTH	HCARE		INDIAN	APOLIS, IN46208			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	ΓΙΟΝ	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	.D BE OPRIAT		1
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	4: -	DATE	
	developed a plan for removal of the				procedures including noti of Administrator, Director		on	
	•	rdy, but based on			Nursing, Social Services		tor	
		view of administrative			and Executive director. A			
	-	was not effective to			in-serviced with pre/post		-	
		ediate Jeopardy prior to			by Director of Nursing on		e,	
	completeion of th	ne survey.			Grievances, Reportable, Abuse Protection and	aliu		
					Investigation policies and			
	Findings include:	:			procedures on 4-21-2011			
					repeated on 5-5-2011. M		nl	
	An undated facili	ity policy, provided by			Director in-serviced Exec Director and Director of N			
	the Executive Di	rector on 4/18/11 at 2:40			on 4-21-2011. Executive		~ 1	
	P.M., titled "Abu	se" indicated:			in-serviced Administrator			
	"Policy				4-21-2011. Executive Di	recto	r	
	It is the policy of	this facility to protect			and Administrator are res		•	
	residents from all	l abusive acts and to			for auditing done in daily with all Department Head		ing	
	comply with state	e and federal laws and			weekly with Chief Operat			
		porting suspected or			Officer and QA Monthly for		ee	
	actual acts.				months and quarterly the			
	Procedure:				Effective 4-21-2011 and of	n-goi	ing.	
		ervice Director shall be						
		isiting the resident,						
	•	sycho/social needs and						
		ventions to address						
	identified needs.	. The contract of the contract						
	11. The Admini	strator shall be						
	responsible for in							
	•	assure the resident is						
		ny further abusive acts						
	_	it is being investigated.						
		nistrator or Designee						
		-						
	shall immediately identify and investigate							
	all incidents. All investigations must be							
	_	n five (5) working						
	days"							
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID	: 6MTI11	Facility 1	ID: 000567 If continu	ation sh	neet Page 18 of 58	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED
NAME OF I	PROVIDER OR SUPPLIER	!! }		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ORTH CAPITOL AVENUE		
	ND MANOR HEALT			INDIAN	APOLIS, IN46208		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
1710	REGUE/HORT OR	ESC IDENTIF TING IN ORWANION)		1710			DATE
IAG	The guidelines for Occurrences, daindicated: "Policy: All unut to the Indiana St will be recorded to insure resident appropriate care Procedure: Facing to report unusual hours of occurrences of unknown injuries of unknown inju	or "Reportable Unusual ated revised 1/25/2006, asual occurrences reported ate Department of Health and tracked or monitored ts are receiving and services. Itities are required by law I occurrences within 24 mee to the Long Term the facility must ensure iolations involving eglect, or abuse, including own source and in of resident property are ately to the administrator d to other officials in State law through edures (including to the I Certification Agency). The examples of the Long Term Care are reportable under both ederal Regulation. These is the recorded by facility are and monitored.		IAG	DEPICIENCI		DATE
	punishment with resulting physical harm or pain, anguish, or deprivation by an						
		ods or services that are					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155711		(X2) M A. BUII		NSTRUCTION 00	COMPL	ETED	
		155711	B. WIN			04/21/20	J11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE		
HIGHLAN	ND MANOR HEALTI	HCARE		1	APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
IAG		in or maintain physical,		TAG	DETCHENCT)		DATE
	mental, or psycho						
	(A) Physical abu	· ·					
		dent abuse with or					
	without injury	dent abuse with or					
	" "	e - is defined as the use					
	` ′	and/or gestured language					
	l '	paraging and derogatory					
	_	s or their families, or					
	within their heari	· ·					
	1) Staff to reside	•					
	· ·	sident verbal threats of					
	harm"						
	An undated polic	y, provided by the DON					
	(Director of Nurs	sing) on 4/20/11 at 11:40					
	A.M., titled "Abı	use Investigation"					
	indicated:						
	Policy:						
	~	nust ensure that all					
	"	s involving mistreatment,					
		, including injuries of					
	· ·	and misappropriation of					
	resident property	*					
	immediately to the						
	1	tor) of the facility and the					
	· ·	partment of Health.					
	(Bold faced) Immediately means as soon as possible, but not to exceed 12 hours after discovery of the incident. It is the policy of this facility that all						
	1 1	•					
	l -	nt abuse, neglect and known source shall be					
	promptly reporte						
	prompny reporte	and morouginy					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		A. BUI	LDING	00 	COMPI 04/21/2	ETED	
		100711	B. WIN		DDDDGG GYMY GM:	0-7/2 1/2	V 1 1
NAME OF I	PROVIDER OR SUPPLIE	R		1	DRTH CAPITOL AVENUE		
HIGHLAI	ND MANOR HEALT	HCARE		1	APOLIS, IN46208		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		πE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		facility management as					
		federal regulations.					
	Procedure:	.: d					
		cident or suspected					
		ent abuse, neglect, or					
	1 " "	nown source be reported					
	1	irector, or his designee					
	incident	y investigate the alleged					
	1	l investigation will be					
		the following as part of					
	the investigation						
	a. Review the c						
		plaint Investigative Report					
		esident's medical record to					
		s leading up to the					
	incident	s reading up to the					
		person(s) reporting the					
	incident	person(s) reporting the					
		y witnesses to the incident					
		resident (as medically					
	appropriate)						
		resident's attending					
		ermine the resident's					
	current mental s						
	g. Interview sta	ff members (on all shifts)					
	1 -	ontact with the resident					
	during the period	d of the alleged incident					
	h. Interview the resident's roommate,						
	family members, and visitors						
	7. Employees of this facility who have						
	been accused of resident abuse may be						
	suspended from	duty until the Executive					
	Director has rev	iewed the results of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711		(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE: COMPL 04/21/2	ETED	
	PROVIDER OR SUPPLIER		29	926 NC	DDRESS, CITY, STATE, ZIP CODE DRTH CAPITOL AVENUE APOLIS, IN46208		
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πЕ	(X5) COMPLETION DATE
	investigation 11. Should the a false report was investigation will family members agencies, etc., we findings" During the entratexecutive Direct A.M., he indicate at the facility's concept. During the daily Executive Direct P.M., a request winvestigations of filed in the last 3 on 4/19/11 at 8: investigations we Executive Direct 1. A grievance/of F and M on 3/8/short and abrupt light - slow to receive (symbol for with (residents). Turn staff doesn't come without) being to the staff of the staff	e investigation reveal that is made/filed, the classe. Residents, Ombudsmen, state ill be notified of the ill be notified of the coron 4/18/11 at 9:15 and the Administrator was corporate office. conference with the coron 4/18/11 at 4:30 and to see conference with the coron 4/18/11 at 4:30 and to see conference with the coron 4/18/11 at 4:30 and to see conference with the coron 4/18/11 at 4:30 and to see conference with the coron 4/18/11 at 4:30 and to see conference with the coron 4/18/11 at 4:30 and the coron and the conference with the coron and the conference with the coron and t					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	NSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMB	BER:	A. BUII	DING	00			
		155711		B. WIN	G			04/21/2	U11
NAME OF P	PROVIDER OR SUPPLIER			•	STREET A	ADDRESS, CITY, STA	ATE, ZIP CODE		
						ORTH CAPITOL			
HIGHLAN	ND MANOR HEALTI	HCARE			INDIAN	APOLIS, IN4620	08		
(X4) ID		TATEMENT OF DEFICIEN			ID		PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED			PREFIX	CROSS-REFERENCI	VE ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFO	RMATION)	-	TAG	DEF	FICIENCY)		DATE
	(Director of Nurs	sing).							
	The DON was no								
		4/20/11 at 9:30 A.							
	During that interv	view, the DON ind	licated						
	-	from her investigat	-						
	Residents F and I	M were abused or i	felt						
	abused, and was	unaware the allega	tion						
	should have been	reported to the Sta	ate						
	Agency. Also du	iring that interview	, the						
	DON indicated sl	he thought the Exe	cutive						
	Director was the	Administrator, and	l she						
		ne Executive Direc							
	•	d she had informed							
		Director (SSD) of the							
	incident during h	` '							
	meident daring it	er mvestigation.							
	The investigation	lacked documenta	ation						
	from staff involve		***************************************						
	mom starr mivory	cu.							
	The record for Re	esident M was revi	ewed						
	on 4/19/11 at 1:1		ic wea						
	011 4/19/11 at 1.19	O 1 .1VI.							
	Current diagnose	s included, but we	ra not						
	•	•							
		egia, muscle spasn	ns,						
	anemia, and decu	ionus uicers.							
	The man of Co. D.	anidani D							
		esident F was revie	ewea						
	on 4/19/11 at 1:5	o P.M.							
	C 1:	a in alreda d. b. d							
	_	s included, but we	re not						
	limited to, autoimmune deficiency								
	syndrome, renal failure, weakness,								
	depression, and h	numan							
FORM CMS-2	567(02-99) Previous Version	ns Obsolete	Event ID: 6	6MTI11	Facility 1	ID: 000567	If continuation sh	eet Pa	ge 23 of 58

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	155711	A. BUII		00	04/21/2	
		100711	B. WIN		ADDRESS SITE STATE SID CODE	04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE		
HIGHLA	ND MANOR HEALTI	HCARE		1	APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	immuno-deficien						
	The records for Residents F and M lacked any documentation from the SSD in regards to the Grievance/Concern filed.						
	During interview with the SSD on 4/19/11 at 4:30 P.M., she indicated if she was involved in filing the Grievance/Concern form she would interview the resident or						
		d, but if the problem was					
	1 ^	ON and/or Executive					
	· ·	en didn't hear about the					
	incident.						
	The incident was Agency.	not reported to the State					
	Director on 4/19/	with the Executive /11 at 11:10 A.M., he					
	discussed in mee						
		er it was felt to be abuse					
		eried as to whether the					
	·	d been informed of these					
		a part of the meetings,					
		rector indicated he					
	(Executive Direc	tor) knew about them,					
	l '	provide information as					
		dministrator was aware					
	of the incidents.						
	2. On 3/16/11, a	Grievance/Concern was					
	filed by Resident	K. The form indicated					

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMPI 04/21/2	LETED	
	PROVIDER OR SUPPLIEF		2926 N	ADDRESS, CITY, STATE, ZIP COL ORTH CAPITOL AVENUE APOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Resident K was CNA #6 pinched #6 had done that Resident K indic CNA #6 touchin present. The investigation DON. The DON's inverted was sent hom meet with the DO counseling and r "Per interview (so one saw this occ assignment was would not care for the counseling and the counsel	crying and she indicated her on the jaw and CNA the "other day". The stated she did not want go her. Family member the was performed by the stigation indicated CNA that day and was to ON on 3/21/11 to review equired performance. Symbol for with) staff - no ur." CNA #6's adjusted so CNA #6 or Resident K again.		CROSS-REFERENCED TO THE APP	PROPRIATE	
	4/20/11 at 8:45 A was off duty 3/18/11. During on 4/20/11 at 9:3 CNA #6 was kep able to complete counsel the emp. The investigation documentation of Resident K or the statement by CNA	n did not include or interviews with e family member, or a of A #6.				
	The record for R	esident K was reviewed				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155711	B. WIN			04/21/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF E	PROVIDER OR SUPPLIER			2926 N	ORTH CAPITOL AVENUE		
	ND MANOR HEALTI	HCARE		INDIAN	IAPOLIS, IN46208		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. TAG DEFICIENCY)		TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENC!)		DATE
	on 4/19/11 at 1:1	5 P.M.					
	_	es included, but were not					
	limited to, cerebr	rovascular					
	The records for F	Residents K lacked any					
	documentation fr	om the SSD in regards					
	to the Grievance	Concern filed.					
	During interview	with the SSD on 4/19/11					
	at 4:30 P.M., she	indicated if she was					
	involved in filing	g the Grievance/Concern					
	form she would i	nterview the resident or					
	residents involve	d, but if the problem was					
		ON and/or Executive					
	1 ^	en didn't hear about the					
	incident.	on draint near about the					
	meraent.						
	 During interview	on 4/20/11 at 9:30 A.M.,					
		ed she did not feel the					
		se, because Resident K					
	1 -	ations in the past, and					
		t the allegation to the					
	1 ^	•					
	1	he indicated she informed					
		rector, but had not					
	informed the Adı	ministrator.					
	Desain a lost and i	idh dha Eaar C					
	_	with the Executive					
		/11 at 11:10 A.M., he					
		Grievance/Concerns are					
	discussed in mee	C / C					
		er it was felt to be abuse					
	_	eried as to whether the					
	Administrator ha	d been informed of these					

	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/21/2011
	PROVIDER OR SUPPLIEF		2926 N	ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE IAPOLIS, IN46208	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
TAG	incidents or was the Executive Direct (Executive Direct but was unable to whether the A of the incidents. 3. A grievance/CE, on 3/30/11, in him a "G d Nand pushed him CNA#3 threw he floor. The investigation During interview at 4:30 P.M., she involved in filing	a part of the meetings, a part	TAG	CROSS-REFERENCED TO THE APPROPRI	
	residents involve reported to the D Director, she oft incident. During interview the DON indicat incident was aburphysical contact did not report the Agency. She incomplete the DON indicates the DON indicates incident was aburphysical contact.	ed, but if the problem was DON and/or Executive en didn't hear about the of on 4/20/11 at 9:30 A.M., ed she did not feel the ase, because there was no and no injury, and she et allegation to the State dicated she informed the tor, but had not informed			

000567

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		ONSTRUCTION 00	(X3) DATE S	
		155711	B. WIN			04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE		
	ND MANOR HEALTI			1	APOLIS, IN46208		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	During interview	with the Executive					
	Director on 4/19/11 at 11:10 A.M., he						
	indicated these G	Grievance/Concerns are					
	discussed in mee						
		er it was felt to be abuse					
	·	eried as to whether the					
		d been informed of these					
		a part of the meetings, rector indicated he					
	(Executive Director) knew about them, but was unable to provide information as						
		dministrator was aware					
	of the incidents.						
	4. On 4/1/11, a (Grievance/Concern was					
	filed by CNA #5	for Resident G. The					
	concern indicated	d Resident N was					
	· -	sident G (who was in					
	bed) with his fist	•					
		ole to read) toward					
	Resident G.						
	The investigation	n was done by the DON.					
		esident G was reviewed					
	on 4/19/11 at 4:4	0 P.M.					
	Current diagnose	es included, but were not					
	· ·	, hypertension, arthritis,					
	pseudo gout, diabetes mellitus, chronic kidney disease, and depression.						
	The record for D	esident N was reviewed					
	on 4/20/11 aat 10						
	511 1/20/11 aut 10	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					

000567

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI		NSTRUCTION 00	COMPI		
		155711	B. WIN			04/21/2	011
	PROVIDER OR SUPPLIER		P. Wat	2926 NO	DDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE APOLIS, IN46208	1	
				L			(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
PREFIX TAG	Current diagnose limited to, dysph disorder, seizure The records for Hacked any docur in regards to the During interview at 4:30 P.M., she involved in filing form she would it residents involve reported to the Director, she ofte incident. During an interview 4/20/11 at 9:30 A	es included, but were not agia, schizo-affective disorder, and dementia. Residents G and N mentation from the SSD Grievance/Concern filed. Twith the SSD on 4/19/11 indicated if she was gethe Grievance/Concern interview the resident or id, but if the problem was ON and/or Executive en didn't hear about the diew with the DON on a.M., she indicated she esident making a threat to		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION DATE
		was abuse, she thought it					
		al contact. She indicated					
	_	t the allegation to the					
	Administrator or	to the State Agency.					
	Director on 4/19/indicated these C discussed in mee discussion whether or not. When que Administrator has	with the Executive /11 at 11:10 A.M., he Grievance/Concerns are tings, along with her it was felt to be abuse eried as to whether the d been informed of these a part of the meetings,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE : COMPL		
ANDILAN	or correction	155711	A. BUII			04/21/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ORTH CAPITOL AVENUE		
HIGHLAN	ID MANOR HEALTI	HCARE		INDIAN	APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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ING		rector indicated he	+	1710			DATE
	(Executive Direc						
	`	provide information as					
		dministrator was aware					
	of the incidents.						
	5. On 4/1/11, a C	Grievance/Concern form					
	was filed by Resi						
		spoken to "abruptly by					
		And inconsistent turning					
	and positioning b	y CNA on 11 - 7.					
	The investigation	was done by the DON.					
	The record for Re on 4/19/11 at 1:1	esident L was reviewed 0 P.M.					
	•	s included, but were not es mellitus, hypertension, th, and anemia.					
	The record for Re on 4/19/11 at 1:1	esident M was reviewed 0 P.M.					
	_	s included, but were not egia, muscle spasms, ibitus ulcers.					
		Residents L and M lacked on from the SSD in					
	-	ievance/Concern filed.					
		with the SSD on 4/19/11 indicated if she was					

NAME OF PROVIDER OR SUPPLIER HIGHLAND MANOR HEALTHCARE (X4) ID SUMMARY STAYEMENT OF DEFICIENCIES (RACH DEPICIENCY MIST BE PERCEDED BY PLLL TAG involved in filing the Grievance/Concern form she would interview the resident or residents involved, but if the problem was reported to the DON and/or Executive Director, she often didn't hear about the incident. During an interview with the DON on 4/20/11 at 9:30 A.M., she indicated she was unaware a resident making an allegation of not receiving needed care during the night would fall under an abuse category. She indicated she did not report this incident to the Administrator or the State Agency. During interview with the Executive Director on 4/19/11 at 11:10 A.M., he indicated these Grievance/Concerns were discussed in meetings, along with discussion whether it was felt to be abuse or not. When queried as to whether the Administrator had been informed of these incidents or was a part of the meetings, the Executive Director j knew about them, but was unable to provide information as to whether the Administrator was aware of the incidents. The Administrator was unavailable for interview during the survey dates.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE S	ETED	
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interview during the survey dates.		of the incidents.						
interview during the survey dates.		The Administrate	or was unavailable for					
		interview during	the survey dates.					
An Immediate Jeopardy was identified on		An Immediate Je	copardy was identified on					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION 00	COMPL	
THAD TETHA	or condition	155711		LDING		04/21/2	
		1667.11	B. WIN		DDDEGG CITY CTATE ZID CODE	022	
NAME OF F	PROVIDER OR SUPPLIER	L.			DRTH CAPITOL AVENUE		
HIGHLAN	ND MANOR HEALT	HCARE		1	APOLIS, IN46208		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		A.M. The Immediate					
		on 3/8/11 when 2					
	•	ined a CNA was short					
	-	responding to their call					
		nadn't been turned all					
	_	Executive Director was					
		nmediate Jeopardy on					
		A.M. related to the lack					
		use and/or neglect,					
	_	tigation of complaints,					
	-	oort alleged abuse to the					
	Indiana State Department of Health for 5						
		iplaints reviewed for the					
		he facility staff submitted					
	a plan of action t	to remove the Immediate					
	Jeopardy on 4/20	0/11 at 8:30 A.M. Based					
	on interview and	review of administrative					
	records on 4/20/	11, it was determined the					
	plan of action ha	d not removed the					
	Immediate Jeopa	ardy and the Immediate					
	Jeopardy continu	ied because of concerns					
	with understandi	ng abuse and abuse					
	investigations an	d protocols. This failure					
		nmediate Jeopardy					
		applemental and 3					
	sampled resident	s (Residents E, F, G, K,					
	L, M, N).						
	3.1-28(a)						
	3.1-28(c)						
	3.1-28(d)						
	3.1-28(e)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MULTIPLE A. BUILDING B. WING	00	(X3) DATE COMP 04/21/ 2	LETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2926 NORTH CAPITOL AVENUE INDIANAPOLIS, IN46208				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE	
F0250 SS=E	social services to highest practicable psychosocial well-Based on record facility failed to of follow up for ass with residents who Grievances/Conctone to resident threat affected for 6 of Social Service (Stample of 3 and standard (Residents 'K', 'Notes include of 1. A current und "Abuse" and problem of 1. A current und "Abuse" and problem of 1. A current und "comply with state regulations for reactual acts. "It is the policy of residents from all comply with state regulations for reactual acts. "The Social Services to higher the social Services of the social Servic	terns, including resident s. The deficient practice 7 residents reviewed for (S) documentation in a supplemental sample of 8 I', 'F', 'M', 'L' and 'G').	F0250	Who is affected: All reside the facility have the potent affected. Who has the potent be affected. All current or admitted residents have the potential to be affected. We systemic changes were puplace to keep the deficient practice from re-occurring: grievance/concern form ha initiated that requires distrito the Administrator, Executirector, DON, and Social Services Director. Social Services will be required to the date a note was made alleged incident and any for needed. The interdisciplinate team will update any assessments documentation resident care plans as need Nursing will update CNA assignments sheets as need Who and How will this be monitored: This will be monitored: This will be monitored: This will be monitored by all parties returned to Social Services kept in the grievance book	ial to be ential to he ential t	04/21/2011	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLE		
ANDILAN	or connection	155711	A. BUI		00	04/21/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	ORTH CAPITOL AVENUE		
HIGHLAN	ND MANOR HEALTI	HCARE		INDIAN	APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	rE	COMPLETION DATE
		sycho/social needs and			log. Executive director and		5.112
	developing interventions to address				Administrator are responsible		
	identified needs.'	"			auditing daily with all Departm Heads, weekly with Chief	ent	
					Operating Officer and QA mon	- 1	
	2. The record for Resident 'K' was				for three months and quarterly thereafter. Effective 4-21-2011		
	reviewed on 4/19	9/11 at 1:15 P.M.			and on-going		
	Diagnoses for Re	esident 'K' included, but					
	were not limited to, cerebral vascular accident, kidney failure, hypertension and left side weakness.						
	A facility "Grievance/Concern Form"						
	1	dicated CNA # 6 pinched					
		er jaw and she did not					
	want him touchir						
		ted 3/16/11 indicated					
		sitting in her wheel chair					
	-	m crying that CNA #6 jaw and she did not want					
	the CNA to touch						
	A social service 1	note dated 4/8/11 and					
		ntry for assessment					
	1 *	3/17/11 indicated nurses					
	` ′	ated no problems during					
	the assessment po	ciiou.					
	The social servic	e record lacked					
	documentation of	f any assessment or					
		address the needs of the					
	resident.						

000567

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155711	B. WIN		-	04/21/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEF	₹		1	ORTH CAPITOL AVENUE		
HIGHLA	ND MANOR HEALT	HCARE		1	APOLIS, IN46208		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORREC			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		riew with the Social					
		on 4/20/11 at 2:10 P.M.,					
		ere were no other social					
		this resident because					
	there were no iss	sues and she was not due					
	to be reassessed	until June.					
	3 The record fo	or Resident 'N' was					
		0/11 at 10:35 A.M.					
	Teviewed on 4/20	0/11 at 10.33 A.W.					
	Diagnoses for Resident 'N' included, but						
	were not limited to, schizo-affective						
	disorder, seizure disorder, and dementia						
	1	nalopathy secondary to an					
	old gun shot wo						
	old gull shot wor	und.					
	A facility "Griev	vance/Concern Form"					
	1	icated Resident 'N' was					
		s roommate while in bed,					
	1	ed up threatening his					
	roommate.	ed up threatening ins					
	100mmate.						
	A nurses note on	4/1/11 at 2:30 P.M.					
	indicated nursing	g was called to Resident					
	1	ound him standing over					
	1	ommate and flexing in a					
	threatening man	· ·					
	A nurses note on	4/1/11 at 3:15 P.M.					
	indicated the Social Service Director had						
	been advised of the resident's behavior.						
	The social service	ce record lacked					
	documentation of	of any assessments or					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711			(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED
NAME OF F	PROVIDER OR SUPPLIER		_	1	ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAN	ND MANOR HEALT	HCARE			ORTH CAPITOL AVENUE APOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	interventions for displayed by Res	the aggressive behavior sident 'N'.		•			
	During an interving Service Director she indicated the this resident was not due for assess 4. The record for reviewed on 4/19 Diagnoses for Rowere not limited deficiency syndrous immunodeficiency depression, renained A facility "Griev dated 3/8/11 indireported CNA #2 respond to the care abrupt when she also indicated the doesn't come interpretation."	iew with the Social on 4/20/11 at 1:35 P.M., most current entry for for 2/9/11 and he was sment again until May. If Resident 'F' was 9/11 at 1:55 P.M. Resident 'F' included, but to, auto immune ome (AIDS), human cy virus (HIV), I failure and weakness. Ince/Concern Form'' icated the resident had 2 had been slow to all light and was short and did respond. Resident 'F' to the room to check and le night without being					
	documentation of interventions to a Resident 'F'.	f any assessments or address the needs of					
	During an interv	iew with the Social					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155711	B. WIN			04/21/20	011
NAME OF E	PROVIDER OR SUPPLIER	!!		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	NO VIDER OR SOLI EIEN				ORTH CAPITOL AVENUE		
HIGHLAN	ND MANOR HEALT	HCARE		INDIAN	APOLIS, IN46208		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	JΈ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		on 4/21/11 at 9:20 A.M.,					
		re were no notes specific					
	to 3/8/11 greivan	ice.					
		r Resident 'M' was					
	reviewed on 4/19	9/11 at 1:10 P.M.					
	_	esident 'M' included, but					
		to, paraplegia, muscle					
	spasms and anen	nia.					
	1	ance/Concern Form"					
		cated the resident had					
	_	2 had been slow to					
		ll light and was short and					
	_	did respond. Resident 'F'					
		e staff on the night shift					
		the room to check and					
	he went the who	le night without being					
	turned.						
	1	ance/Concern Form"					
		cated the resident had					
	1 ^	on the 11-7 shift had					
	^ -	to him and the CNA on					
		d been inconsistent with					
	turning and posit	tioning him.					
	The social service record lacked						
		f any assessments or					
		address the needs of					
	Resident 'F'.						
	During an interv	iew with the Social					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155711	B. WIN			04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	ROVIDER OR SUPPLIER			2926 N	ORTH CAPITOL AVENUE		
HIGHLAN	ND MANOR HEALT	HCARE		INDIAN	IAPOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		on 4/21/11 at 9:20 A.M.,					
		re were no notes specific					
	to 3/8/11 or 4/1/1	11 greivance.					
		r Resident 'L' was					
	reviewed on 4/19	9/11 at 1:10 P.M.					
	Diagnoses for Re	esident 'L' included, but					
	were not limited						
		emia and chronic mild					
	diarrhea.	cima and cinomic iiiid					
	diairiica.						
	A facility "Griev	ance/Concern Form"					
	1	cated the resident had					
		on the 11-7 shift had					
	_	to him and the CNA on					
	1 ^ ^	d been inconsistent with					
	turning and posit	noning mm.					
	The social service	e record lacked					
	documentation o	f any assessments or					
		address the needs of					
	Resident 'F'.						
	During an interv	iew with the Social					
	•	on 4/21/11 at 9:20 A.M.,					
	she indicated there were no notes specific to 4/1/11 greivance.						
	-						
	7. The record for Resident 'G' was						
	reviewed on 4/19	9/11 at 1:00 P.M.					
	Diagnoses for Re	esident 'G' included, but					
	-	to, stroke, hypertension,					
		. , , , ,			!		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE (COMPL 04/21/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u></u>	<u>.</u>		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
HIGHLAI	ND MANOR HEALT	HCARE			ORTH CAPITOL AVENUE APOLIS, IN46208		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
	arthritis, diabetes, depression and chronic kidney disease.						
	A facility "Grievance/Concern Form" dated 4/1/11 indicated Resident 'Gs' roommate (Resident 'N') was standing over me while in bed with his fist balled up threatening me.						
	A nurses note on 4/1/11 at 2:30 P.M. indicated nursing was called to Resident 'Gs' room and found the roommate (Resident 'N') standing over Resident 'G's' bed and flexing in a threatening manner.						
	indicated the Soc	4/1/11 at 3:15 P.M. cial Service Director had the resident's behavior.					
	The social service record lacked documentation of any assessments or interventions to address the needs of Resident 'G'.						
	During an interview with the Social Service Director on 4/19/11 at 4:30 P.M., she indicated Resident 'G' was not due for any assessments yet.						
	4:30 p.m., the So indicated if she v Grievance/Conce	interview on 4/19/11 at ocial Service Director was involved in filing the ern form, she would ident or residents					

PRINTED: 05/10/2011 FORM APPROVED OMB NO. 0938-0391

l	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/24/2011
		155711	B. WING	L DDDDGG GWYL GWLG GWD	04/21/2011
NAME OF I	PROVIDER OR SUPPLIER		ı	ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE	
HIGHLAN	ND MANOR HEALTI			IAPOLIS, IN46208	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E DATE
	involved, but if the	he problem was reported			
		or Executive Director,			
	she often didn't h	near about the incident.			
	3.1-34(a)				
	3.1-3 4 (a)				
	, ,				
F0490		administered in a manner use its resources effectively			
	and efficiently to a	ttain or maintain the highest			
	practicable physic psychosocial well-	al, mental, and being of each resident.			
SS=K	1	review and interview, the	F0490	All residents have the potentia	
	*	ensure the Administrator		be affected. Administrator, Ed Grogg, is in the facility several	
	was informed and			days a week. Executive	
	_	d interventions of terns filed by 7 of 8		Director,Patrick Hall and DON Norma Cork, are in contact with	
	Grievances/Conc	Lettis filed by / 01 o		Mr. Grogg daily through phone	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6MTI11

Facility ID:

000567 If continu

If continuation sheet Page 40 of 58

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155711	B. WIN	IG		04/21/20	011
NAME OF	PROVIDER OR SUPPLIER	,		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	I KOVIDEK OK SOI I EIEI			2926 N	ORTH CAPITOL AVENUE		
HIGHLA	ND MANOR HEALT	HCARE		INDIAN	IAPOLIS, IN46208		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	residents in a sar	nple of 3 and a			calls and emails. Mr. Grogg is		
	supplemental sai	mple of 8 identified in 5			made aware of all issues relat		
	of 9 Grievance/C	Concern forms reviewed			to patient care, plant, employed and financial. Mr. Grogg review		
	related to allegat	tions of abuse. (Residents			all consultant reports,incident	,ws	
	E, F, G, K, L, M				reports, and unsatisfactory wo	ork	
	L, 1, 0, 11, E, 111	, 11).			reports. Mr. Grogg, Mr. Hall, a		
	This deficient	nation regulted in			Norma Cork review and discus		
	_	actice resulted in			patient care indicators every		
	_	ardy. The immediate			week, which includes incidents		
	1 " "	entified on 4/19/11 and			through a formal report which complied for the Board of	is	
		The Executive Director			Directors monthly. Administra	itor	
	was notified of t	he Immediate Jeopardy			will sign reports weekly. Execu		
	on 4/19/11 at 11	:10 A.M. The facility			Director and Administrator are		
	developed a plar	for removal of the			responsible for auditing done i	in	
		ordy, but based on			daily meeting with all Departm	ent	
	1	view of administrative			Heads, weekly with Chief		
		was not effective to			Operating Officer and QA mor		
	1				for three months and quarterly thereafter. Posting of procedu		
		ediate Jeopardy prior to			for Abuse known and or allege		
	completeion of t	ne survey.			policy with action steps at cen		
					time clock for every employee		
	Findings include	:			see every in/out scheduled.		
					Resident Council given policy		
	An undated facil	ity policy, provided by			procedure on Abuse Protection		
	the Executive Di	rector on 4/18/11 at 2:40			and Investigation. All Families and guardians mailed policy a		
	P.M., titled "Abı	use" indicated:			procedure on Abuse Protection		
	"Policy				and Investigation. All staff	''	
	1	f this facility to protect			in-serviced on 4-21-2011and		
	1 1	I abusive acts and to			repeated on 5-5-2011 on		
					expanded grievance form which		
	1 * *	e and federal laws and			now includes signature lines for		
	~	eporting suspected or			Administrator, Executive Direct		
	actual acts.				Director of Nursing and Social Services Director. Form include		
	Procedure:				policy and step- by-step	103	
	11. The Admin	istrator shall be			instructions on investigation		
	responsible for i	nitiating proper			procedures and reporting		
	_	assure the resident is			procedures including notification	on	

000567

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155711	A. BUI		00	04/21/2	
		100711	B. WIN		ADDRESS CITY STATE ZIR CODE	04/21/2	011
NAME OF	PROVIDER OR SUPPLIE	₹		1	ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE		
HIGHLA	ND MANOR HEALT	HCARE			APOLIS, IN46208		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	,		DATE
	1 *	ny further abusive acts			of Administrator, Director of Nursing, Social Services Direct	tor	
	1	nt is being investigated.			and Executive director. All state		
		inistrator or Designee			in-serviced with pre/post testi		
		y identify and investigate			by Director of Nursing on Abus	se,	
	1	l investigations must be			Grievances, Reportable, and Abuse Protection and		
	1 ^	n five (5) working			Investigation policies and		
	days"				procedures on 4-21-2011 and		
	, , ,	11 11 4 BOY			repeated on 5-5-2011. Medica	al	
	_	cy, provided by the DON			Director in-serviced Executive Director and Director of Nursir	na l	
	`	sing) on 4/20/11 at 11:40			on 4-21-2011. Executive Direct	-	
		use Investigation"			in-serviced Administrator on		
	indicated:				4-21-2011. Executive Directo		
	Policy:				and Administrator are respons for auditing done in daily meet		
	1 -	must ensure that all			with all Department Heads,	ii ig	
	1 ~	is involving mistreatment,			weekly with Chief Operating		
	1 -	e, including injuries of			Officer and QA Monthly for three		
	1	, and misappropriation of			months and quarterly thereafter Effective 4-21-2011 and on-go		
	resident property				Ellective 4-21-2011 and on-go	iiig.	
	1	he Administrator					
	`	ctor) of the facility and the					
	1	partment of Health.					
	1 '	mediately means as soon					
		not to exceed 12 hours					
	after discovery of						
	1 .	f this facility that all					
	_	nt abuse, neglect and					
		known source shall be					
		ed and thoroughly					
		facility management as					
	1 -	ederal regulations.					
	Procedure:						
	1	eident or suspected					
		ent abuse, neglect, or					
	injury of an unk	nown source be reported					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE	J 5-7/2 1/2	
HIGHLAI	ND MANOR HEALTI	HCARE		INDIAN	APOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	will immediately incident 2. An internal conducted using the investigation: a. Review the conducted using the investigation: a. Review the conducted using the investigation: a. Review the conducted complete incident to the inciden	ompleted claint Investigative Report sident's medical record to leading up to the person(s) reporting the witnesses to the incident resident (as medically resident's attending rmine the resident's atus as needed if members (on all shifts) ntact with the resident l of the alleged incident resident's roommate, and visitors of this facility who have resident abuse may be duty until the Executive ewed the results of the					

000567

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155711	A. BUII B. WIN	LDING G		04/21/2	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	ļ	
HIGHI AI	ND MANOR HEALT	HCARE		1	ORTH CAPITOL AVENUE APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	711 0210, 111 10200		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	findings"						
	During the entra	nce conference with the					
		or on 4/18/11 at 9:15					
		rive Director indicated					
	the facility Admi	nistrator was at the					
	corporate offices						
	During the daily	conference with the					
	1 -	or on 4/18/11 at 4:30					
	P.M., a request w						
		9 grievances/concerns					
	filed in the last 3	months.					
	On 4/19/11 at 8:1	O A M these					
		ere provided by the					
	Executive Direct	•					
	1. A grievance/c	•					
		M on 3/8/11 indicated					
		and abrupt when					
		ll light - slow to respond.					
		(symbol for with)					
	· ` `	sidents). Turns not being doesn't come into room					
		entire noc (night) (symbol					
	for without) bein						
	101 Williout) 00III	5					
	The investigatio	n was done by the DON					
	(Director of Nurs	sing).					
	The DON was no	ot available to be					
		4/20/11 at 9:30 A.M.					
		view, the DON indicated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155711		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED	
	PROVIDER OR SUPPLIER		p. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE DRTH CAPITOL AVENUE APOLIS, IN46208	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	(X5) COMPLETION DATE
	Residents F and I abused, and was should have beer Agency. Also du DON indicated s Director was the had reported to the She also indicate Social Services I incident during he The investigation from staff involve. The record for Re on 4/19/11 at 1:1. Current diagnose limited to, paraple anemia, and decumentation of the record for Re on 4/19/11 at 1:5. Current diagnose limited to, autoin syndrome, renal depression, and reimmuno-deficient. The records for Fany documentation and documentation of the records for Fany documentation.	esident M was reviewed 0 P.M. es included, but were not legia, muscle spasms, libitus ulcers. esident F was reviewed 5 P.M. es included, but were not mune deficiency failure, weakness,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	155711	A. BUII	LDING	00	COMPL 04/21/2	
		1337 11	B. WIN			04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE		
HIGHI AI	ND MANOR HEALTI	HCARE			APOLIS, IN46208		
				l	711 0210, 111 10200		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG	During interview at 4:30 P.M., she involved in filing form she would it residents involve reported to the D. Director, she offer incident. During interview Director on 4/19/2 indicated these G. discussed in meet discussion whether or not. When quantification of the Executive Director on 4/19/2 indicated these G. Executive Director on the Executive Director on the Executive Director on the Executive Director on the Executive Director of the incidents. 2. On 3/16/11, a filed by Resident K. was G. C. A. #6 pinched #6 had done that Resident K. indicated the control of the incidents.	with the SSD on 4/19/11 indicated if she was gethe Grievance/Concern interview the resident or d, but if the problem was ON and/or Executive en didn't hear about the with the Executive //11 at 11:10 A.M., he Grievance/Concerns are tings, along with her it was felt to be abuse eried as to whether the d been informed of these a part of the meetings, rector indicated he tor) knew about them, o provide information as dministrator was aware Grievance/Concern was EK. The form indicated berying and she indicated her on the jaw and CNA		TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155711		(X2) MI A. BUII		NSTRUCTION 00	COMPL	ETED	
		155711	B. WIN			04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE		
HIGHLAN	ND MANOR HEALTI	HCARE		1	APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	DON.						
	#6 was sent homemeet with the DC counseling and re "Per interview (some saw this occur assignment was a would not care for Review of CNA; 4/20/11 at 8:45 A was off duty 3/16 3/18/11. During on 4/20/11 at 9:3 CNA #6 was kep able to complete counsel the employment of the investigation documentation of Resident K or the statement by CN.	adjusted so CNA #6 or Resident K again. #6's employee record on A.M. indicated CNA #6 6/11, 3/17/11, and interview with the DON 0 A.M., she indicated of duty until she was her investigation and oyee. In did not include or interviews with the family member, or a A #6. esident K was reviewed					
	limited to, cerebr	es included, but were not rovascular accident, ypertension, and left side					
	The records for F	Residents K lacked any					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		A. BUIL	DING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/20	ETED	
	PROVIDER OR SUPPLIER		B. WING	STREET A	DRTH CAPITOL AVENUE	J 0-1/2 1/20	
HIGHLA	ND MANOR HEALTI			INDIAN	APOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	documentation fr to the Grievance	om the SSD in regards //Concern filed.					
	at 4:30 P.M., she involved in filing form she would i residents involve reported to the D	with the SSD on 4/19/11 indicated if she was the Grievance/Concern nterview the resident or d, but if the problem was ON and/or Executive en didn't hear about the					
	the DON indicate "pinch" was abus made false accus she did not repor State Agency. Sl	on 4/20/11 at 9:30 A.M., ed she did not feel the se, because Resident K ations in the past, and t the allegation to the he indicated she informed rector, but had not ministrator.					
	Director on 4/19/indicated these G discussed in mee discussion wheth or not. When qu Administrator ha incidents or was the Executive Direct but was unable to	with the Executive /11 at 11:10 A.M., he drievance/Concerns are tings, along with her it was felt to be abuse eried as to whether the d been informed of these a part of the meetings, rector indicated he tor) knew about them, to provide information as dministrator was aware					

PRINTED: 05/10/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711		(X2) MULTIPI A. BUILDING B. WING		TRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u></u>			DRESS, CITY, STATE, ZIP CODE		
HIGHLAI	ND MANOR HEALT	HCARE			RTH CAPITOL AVENUE POLIS, IN46208		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF		E	COMPLETION
TAG	3. A grievance/o E, on 3/30/11, in him a "G d Mand pushed him CNA #3 threw has floor. The investigation During interview at 4:30 P.M., she involved in filing form she would residents involved reported to the Director, she off incident. During interview the DON indicated incident was abure physical contact did not report the Agency. She incident was abure physical contact did not report the Administrator During interview Director on 4/19 indicated these Contact discussed in meeting discussed in meeting discussion whether the discussion whether the Administrator discussion whether the Administration of t	concern filed by Resident dicated CNA #3 called M F, I'll kill you into his wheelchair Also, is "reacher" onto the mass done by the DON. What with the SSD on 4/19/11 indicated if she was gethe Grievance/Concern interview the resident or ed, but if the problem was DON and/or Executive en didn't hear about the mass done injury, and she is allegation to the State dicated she informed the tor, but had not informed			CROSS-REFERENCED TO THE APPROPRIAT	TE TO THE	DATE

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		B. WING	STREET A	DRTH CAPITOL AVENUE APOLIS, IN46208	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	incidents or was the Executive Di (Executive Direc but was unable to	d been informed of these a part of the meetings, rector indicated he tor) knew about them, o provide information as dministrator was aware					
	filed by CNA #5 concern indicated standing over Re bed) with his fist	Grievance/Concern was for Resident G. The d Resident N was sident G (who was in balled making ole to read) toward					
		n was done by the DON. esident G was reviewed 0 P.M.					
	limited to, stroke	es included, but were not e, hypertension, arthritis, betes mellitus, chronic end depression.					
	The record for Roon 4/20/11 aat 10	esident N was reviewed 0:35 A.M.					
	limited to, dysph	es included, but were not agia, schizo-affective disorder, and dementia.					
	The records for F	Residents G and N					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 04/21/2	LETED	
	PROVIDER OR SUPPLIER		2926 N	ADDRESS, CITY, STATE, ZIP COD ORTH CAPITOL AVENUE APOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
		mentation from the SSD Grievance/Concern filed.				
	at 4:30 P.M., she involved in filing form she would it residents involve reported to the D Director, she officincident. During an interved 4/20/11 at 9:30 A was unaware a reanother resident had to be physical she did not report Administrator or During interview Director on 4/19/20/11 indicated these C discussed in meed discussion whether or not. When que Administrator had incidents or was the Executive Director on the Executive D	with the SSD on 4/19/11 indicated if she was gethe Grievance/Concern interview the resident or ed, but if the problem was ion and/or Executive en didn't hear about the liew with the DON on A.M., she indicated she esident making a threat to was abuse, she thought it al contact. She indicated it the allegation to the to the State Agency. With the Executive //11 at 11:10 A.M., he brievance/Concerns are etings, along with her it was felt to be abuse eried as to whether the id been informed of these a part of the meetings, rector indicated he etor) knew about them, to provide information as dministrator was aware				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE COMPL		
		155711	A. BUII B. WIN			04/21/2	011
	PROVIDER OR SUPPLIER		p. wax	2926 N	ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE APOLIS, IN46208		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	\neg	ID	PROVIDENCEN AN OF CONDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	5. On 4/1/11, a (Grievance/Concern form					
	was filed by Resi	idents L and M					
		g spoken to "abruptly by					
	nurse on 11 - 7."	And inconsistent turning					
	and positioning b	oy CNA on 11 - 7.					
	The investigation	n was done by the DON.					
	The record for R	esident L was reviewed					
	on 4/19/11 at 1:1						
	Current diagnose	es included, but were not					
		es mellitus, hypertension,					
	shortness of brea						
	The record for Roon 4/19/11 at 1:1	esident M was reviewed 0 P.M.					
	Current diagnose	es included, but were not					
		legia, muscle spasms,					
	anemia, and decu						
	The records for F	Residents L and M lacked					
	any documentation	on from the SSD in					
	regards to the Gr	ievance/Concern filed.					
	_	with the SSD on $4/19/11$					
	· ·	indicated if she was					
	1	g the Grievance/Concern					
		nterview the resident or					
		d, but if the problem was					
	_	ON and/or Executive					
	· ·	en didn't hear about the					
	incident.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MULT A. BUILDI B. WING		00	(X3) DATE: COMPL 04/21/2	ETED	
	PROVIDER OR SUPPLIER		5	2926 NC	DDRESS, CITY, STATE, ZIP CODE DRTH CAPITOL AVENUE APOLIS, IN46208	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	4/20/11 at 9:30 A was unaware a reallegation of not during the night category. She in this incident to the State Agency. During interview Director on 4/19 indicated these C discussed in meet discussion whether or not. When que Administrator has incidents or was the Executive Director on the Executive Director of the incidents. The Administrate interview during An Immediate Jeta 4/19/11 at 11:00 Jeopardy began or residents complained abrupt when lights, and they here	iew with the DON on A.M., she indicated she esident making an receiving needed care would fall under an abuse dicated she did not report he Administrator or the read as to whether the did been informed of these a part of the meetings, rector indicated he etor) knew about them, to provide information as dministrator was aware or was unavailable for the survey dates. copardy was identified on A.M. The Immediate on 3/8/11 when 2 ined a CNA was short responding to their call hadn't been turned all Executive Director was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711		(X2) MU A. BUII B. WIN	LDING	nstruction 00	(X3) DATE S COMPL 04/21/20	ETED	
NAME OF I	PROVIDER OR SUPPLIER		p. with	STREET A	DRTH CAPITOL AVENUE		
HIGHLAND MANOR HEALTHCARE				INDIAN	APOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	4/19/11 at 11:10 of identifying abinadequate inves and failure to rep Indiana State Derof 9 conerns/comlast 3 months. Taplan of action the Jeopardy on 4/20 on interview and records on 4/20/10 plan of action has Immediate Jeopardy continuation with understandinivestigations and to remove the Imaffected 7 of 8 su	A.M. related to the lack use and/or neglect, tigation of complaints, nort alleged abuse to the partment of Health for 5 aplaints reviewed for the he facility staff submitted to remove the Immediate of 11 at 8:30 A.M. Based review of administrative 11, it was determined the d not removed the redy and the Immediate set the Immediate Immediate Immediate Jeopardy applemental and 3 s (Residents E, F, G, K,					
F0514	each resident in a professional stand complete; accurat	naintain clinical records on ccordance with accepted lards and practices that are ely documented; readily estematically organized.					
	information to ider	must contain sufficient ntify the resident; a record of essments; the plan of care					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155711		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A. BUILDING 00 COMPLET B. WING 04/21/201			ETED		
	PROVIDER OR SUPPLIER			2926 N	ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE IAPOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
SS=D	preadmission scresstate; and progress Based on record facility failed to were complete an in regards to doc and tracheostomy reviewed for doc of 3 (Residents 'I Findings include 1. A current und "Documentation' #1 indicated, "All pertinent and/or resident daily." 2. A current und "Charting" and p Director (E.D.) of indicated, "Policy Statemer All services provishall be recorded record. Policy Interpreta 1. All observations services perform in the resident's of the record for th	review and interview, the ensure clinical records and accurately maintained umentation of catheter by care for 2 of 3 residents umentation in a sample D' and 'B'). : ated facility policy titled and provided by LPN all shifts are to make general notes on each ated facility policy titled, rovided by the Executive on 4/19/11 at 2:20 P.M. It in the resident at in the resident's medical tion and Implementation ons, medications given, ed, etc., must be recorded	F0	514	All residents are at risk for bei affected. A complete audit of MAR and TAR documentation was conducted by DON on 4-21-2011. Identified deficient were addressed with responsistaff LPNs. A documentation in-service was done with all nursing staff on 4-21-2011. Medical records personnel ha also been counseled as on-go audits have not been complet as scheduled to cover all resid MAR and TARs. DON will redocumentation daily with each shift and address deficiencies MAR and TARs will be placed same book. Medical records mandated to do daily audits a copy results to DON for follow as indicated. Nurses are responsible for documentation Medical records are responsible for audits. DON will monitor through audits weekly for nine days, monthly thereafter wher threshold is met. QA will monevery month for three months quarterly for three periods. Effective 4-21-2011 and on-go	sies ble sing ed dent view i in nd up	04/21/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	COMPL	ETED	
		155711	B. WIN			04/21/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE		
HIGHLAN	ND MANOR HEALTI	HCARE		1	APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
	were not limited	esident 'D' included but to anal fistula, peripheral					
		dementia with agitation, sis and cerebral vascular					
	An April 2011 ph originally dated 7 care on every shi	7/9/09, indicated catheter					
	The medication administration record (MAR) for 2011 lacked documentation of catheter care for the following dates:						
	2/12, 2/13, 2/14, 2/20, 2/23, 2/24, Evening shift: 2/	, 2/4, 2/7, 2/8, 2/9, 2/11, 2/15, 2/16, 2/17, 2/18, 2/25, 2/26, 2/27, 2/28/11 (2/11, 2/4, 2/19, 2/28/11 11, 2/13, 2/14, 2/18,					
	3/15, 3/16, 3/17, 3/23, 3/26, 3/27, Evening Shift: 3 3/22, 3/24, 3/25, 3/31/11	/4/11, 3/8, 3/13, 3/18, 3/27, 3/28, 3/29, 3/30, 11, 3/6, 3/8, 3/13, 3/14,					
	4. The record for reviewed on 4/18	Resident 'B' was 1/11 at 9:45 A.M.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155711		(X2) MULTIPI A. BUILDING B. WING	E CON	00	(X3) DATE S COMPL 04/21/2	ETED	
	PROVIDER OR SUPPLIER		STR 292	6 NC	DDRESS, CITY, STATE, ZIP CODE DRTH CAPITOL AVENUE APOLIS, IN46208	l	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
-	Diagnoses for Rewere not limited	esident 'B' included but to diabetes, diabetic ephalopathy, dysphasia					
	An April 2011 pl originally dated 3 care every shift.	nysician's order, 3/13/10, indicated trach					
	The MARs for 20 documentation o following dates:	011 lacked f trach care for the					
	2/23, 2/25, 2/26,	2/15, 2/18, 2/20, 2/21, 2/27, 2/28/11 3, 2/14, 2/18, 2/28/11					
	3/21, 3/22, 3/24, 3/31 Evening Shift: 3	3/16, 3/17, 3/19, 3/20, 3/25, 3/26, 3/27, 3/30, /31/11 5, 3/16, 3/17, 3/18, 3/19,					
	4:30 P.M., the m	conference on 4/18/11 at issing documentation for trach care was requested.					
	4/19/11 at 9:30 A further document	iew with LPN #1 on A.M., she indicated no station could be found for eter or trach care for D'.					

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1	NT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER: 155711	(X2) MULTIPLE CC A. BUILDING B. WING	00	— COMF 04/21/	E SURVEY PLETED 2011
HIGHLA	PROVIDER OR SUPPLIE	HCARE	2926 N INDIAN	ADDRESS, CITY, STATE, ZIP C ORTH CAPITOL AVENU APOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE , DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
IAG	3.1-50(a)(1) 3.1-50(a)(2)	X LOC IDEN HE HING INFORMATION)	IAG	DIAMENCE)		DATE